

Oceania Care Company Limited - Whitianga Continuing Care

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Oceania Care Company Limited
Premises audited:	Whitianga Continuing Care
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 24 June 2021 End date: 25 June 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	46

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Whitianga Continuing Care provides rest home and hospital level care for up to 54 residents. The facility is operated by Oceania Healthcare Limited and is managed by a business and care manager.

Residents and families reported satisfaction with the care provided.

This surveillance audit was conducted against the Health and Disability Service Standards. The audit process included review of policies and procedures, review of residents' and staff files, observations, and interviews with residents, family/whānau, management, staff and a general practitioner.

There were no areas requiring improvement from the previous audit and no new requirements from this audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
--	--	--

Effective communication to residents and their family members occurs and interpreter service can be accessed as required.

A complaints register is maintained with complaints resolved promptly and effectively. There have been no complaint investigations by an external agency since the previous audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
---	--	--

Oceania Healthcare Limited is the governing body responsible for the services provided at Whitianga Continuing Care. An organisational strategic plan and a specific business plan for the facility includes a mission, vision and values statement that reflects a person/family-centred approach for all residents. Information packs provided to residents and their families on admission and displayed within the facility include this information. Staff are also provided with this information during their orientation and ongoing training.

Quality and risk management systems that support the provision of clinical care and quality improvement are well embedded. Policies are current and reflect good practice. Reports to the national office provide monthly monitoring of service delivery.

The service is managed by a business and care manager who has been in the position for six years. The business and care manager is supported by the clinical manager and Oceania senior managers.

An internal audit programme is in place. Adverse events are documented on adverse events forms electronically. Corrective action plans for deficits relating to internal audits, adverse events and satisfaction surveys are developed, implemented, monitored and signed off. Various meetings are held on a regular basis.

Actual and potential risks, including health and safety risks, are identified and mitigated.

Policies and procedures on human resources management are implemented. Staff have the required qualifications. An in-service education programme is provided and staff performance is monitored.

A documented rationale for determining staffing levels and skill mix is in place. Registered nurses are always rostered on duty. The business and care manager and clinical manager are rostered on call after hours.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
--	--	--

The service is delivered in a manner that provides continuity and promotes a team approach for the care of the residents. There are policies and procedures in place, which support assessment, planning, provision of care, evaluation and transfers for residents. These safely meet their needs and the facility's contractual obligations. The multidisciplinary team includes a clinical manager, registered nurses and a facility general practitioner who assess the needs of the resident on admission. Care plans are individualised, and resident focused with an interRAI assessments completed. Files reviewed demonstrated the care provided and the needs of the residents are reviewed and evaluated in a timely manner.

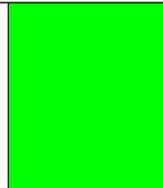
The service provides a planned activity program which has a variety for individual and group activities and maintains a link with the community.

The medication policy identifies with current best practice for medication management and the staff who administer the medications are competent in medication management.

The onsite kitchen meets the nutritional needs of the residents and there is food available 24 hours of the day. Residents with specific dietary requirements and likes and dislikes are well catered for. On discussion with residents and family they expressed satisfaction with the meals and the choice available. The service has a four-week rotating menu which has been approved by a registered dietitian.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

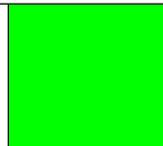


Standards applicable to this service fully attained.

The building warrant of fitness is displayed at the main entrance to the facility. There have been no structural alterations since the previous audit

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were residents using enablers and restraints at the time of audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection control programme is led by the clinical manager. The infection control policy identifies current best practice for infection control management. Infection data is collated on a monthly basis by the clinical manager and presented at the monthly infection control meeting, registered nurse meeting and general staff meeting.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	0	0	0	0
Criteria	0	39	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and families on admission and complaints information and forms are available at the main entrance.</p> <p>One complaint has been received in the last year and this has been entered into the complaints register. Complaint documentation was reviewed and actions taken were documented and completed within the timeframes specified in the Code. The action plan reviewed showed any required follow up and improvements have been made where possible.</p> <p>The BCM is responsible for complaint management and follow-up. Staff interviewed confirmed a sound understanding of the complaints process and what actions are required.</p> <p>There have been no complaint investigations by external agencies since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	<p>FA</p>	<p>Residents and families interviewed stated they are kept well informed about any changes to their/their relative's status and outcomes of regular and any urgent medical reviews. The satisfaction survey for 2021 and resident's files confirmed this. Staff understood the principles of open disclosure, which is supported by policy and procedures that meet the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Newsletters are</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>sent to families that keep them up to date with the activities relating to the facility and residents.</p> <p>Interpreter services can be accessed via the District Health Board (DHB) when required. The business and care manager (BCM) advised they can also contact the local language school, or resident's family members as well as staff who can act as interpreters, where appropriate. There is a wide range of staff with different cultures who have English as their second language.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The Oceania Healthcare Limited vision, values, mission statement and philosophy are displayed. The organisation has systems in place recording the scope, direction and goals of the organisation. An operational and business plan for Whitianga includes strengths and weaknesses and an executive summary. The BCM stated they review the plan regularly. The managers provide monthly status reports to the national office. Reports include, but are not limited to, quality and risk management issues, occupancy numbers, human resource issues, complaints, abuse, quality improvements, policies, education, issues, internal audit outcomes and clinical indicators.</p> <p>The facility is managed by an experienced BCM who has been in the position for six years. The BCM advised they have resigned from the position and the organisation is currently advertising for a replacement. The clinical manager (CM) is responsible for overseeing the clinical services. The CM has been in this role for approximately two years and prior to that was part of the RN team working on the floor in the facility. The appointment of the CM has been notified to HealthCERT.</p> <p>Whitianga Continuing Care (Whitianga) is certified to provide hospital and rest home level care. All beds have been approved as dual purpose apart from one room which is certified for rest home level only. Contracts with the DHB include aged related residential care services (23 hospital and 22 rest home), respite (nil), long term chronic health conditions (one resident under the age of 65 years) and post-acute convalescent care (PACC) (one hospital level). Whitianga also has a contract with the Accident Compensation Commission (ACC) on a case-by-case basis.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects</p>	<p>FA</p>	<p>The Oceania documented quality improvement policy defines quality, quality assurance and quality improvement. The facility's quality improvement is defined in the quality plan, the policies and procedures and Oceania Healthcare model of care and quality and risk framework which guides the quality programme.</p> <p>Service delivery is monitored through robust reporting systems utilising a number of clinical indicators such as infections, choking, complaints, falls, medication errors, weight loss, wounds, and food safety and implementation of the internal audit programme. Clinical indicators are collated monthly by the CM. The internal audit programme is implemented as scheduled and documentation reviewed evidenced quality improvement data is managed well. Data is being collected and collated with analysis of data that identifies any trends. Corrective action plans from quality activities are developed, implemented, reviewed and closed out. Month by month graphs are generated as well as benchmarking with other like facilities within the group.</p>

<p>continuous quality improvement principles.</p>		<p>All aspects of quality improvement, risk management and clinical indicators are discussed at the various meetings held. Copies of meeting minutes are available for staff to review and sign to confirm that they have read them. Staff confirmed they are kept well informed of quality improvements and any subsequent changes to procedures and practice through the meetings. Residents and families are notified of changes and events at the residents' meetings. Residents and families interviewed confirmed this.</p> <p>Satisfaction surveys for residents and families are completed as part of the annual internal audit programme. Surveys reviewed evidenced high satisfaction with the services provided apart from food choices. Documentation reviewed evidenced this has been resolved and residents stated they have at least two choices now and they are happy with that.</p> <p>Policies are current and align with the Health and Disability Sector Standards and reflect accepted good practice guidelines. Policies are reviewed nationally with comments sought from staff and reviewed by the clinical governance group. New and revised policies are discussed at staff meetings and as part of relevant in-service education. Staff sign to confirm that they have read and understood each new policy and/or update. Staff confirmed they are made aware of new and updated policies.</p> <p>The organisation has a risk management programme in place. A health and safety plan and objectives, plus policies and procedures, are documented along with a hazard management programme. Health and safety is monitored as part of the annual internal audit programme. Staff confirmed an awareness of health and safety processes and of their responsibilities to report hazards, accidents and incidents promptly. Accidents, incidents and corrective actions are discussed at staff meetings.</p> <p>Health and safety representatives demonstrated good knowledge of the role and have completed the health and safety training. Hazard identification forms are completed when a hazard is identified, addressed and risks minimised. There is a national risk register plus a site-specific hazard/risk register that is reviewed at each health and safety meeting and updated at least annually or when a new hazard is identified. Review of the meeting minutes confirmed this.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported</p>	<p>FA</p>	<p>Adverse, unplanned or untoward events are documented by staff on adverse event forms electronically. All care issues are received by the CM who is alerted by email. Sentinel events, including but not limited to, absconding and sudden death are reported to the appropriate person in national office. All incidents/accidents are investigated with corrective actions developed and implemented and closed out. Documentation reviewed and interviews with staff indicated adverse events are managed well.</p> <p>Resident's files evidenced communication with families following adverse events involving the resident, or any change in the resident's health status. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Policies and procedures comply with essential notification reporting. Staff stated they are made aware of their</p>

<p>to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files and other documentation confirmed this. The BCM reported there have been Section 31 notifications to HealthCERT since the previous audit. These include two power outages, a call bell outage and an event leading to death of a resident. Review of documentation relating to this latter notification evidenced the investigation undertaken and the action plan completed.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>A staffing policy and procedures that meets the requirements of legislation is in place. The skills and knowledge required for each position is documented in job descriptions, with accountabilities, responsibilities and reporting lines clearly identified.</p> <p>Staff files reviewed demonstrated that recruitment processes for all staff include an application, CV, reference checks, police vetting, a current work visa where relevant, identification verification, a position specific job description and a signed employment agreement.</p> <p>A system is in place to ensure that annual practising certificates are current. Current certificates were evidenced for all staff and contractors who required them.</p> <p>An orientation/induction programme is available that is position specific and covers the essential components of the services provided. Health care assistants (HCAs) are buddied with an experienced staff member until they demonstrate competency on specific tasks.</p> <p>The education and research manager and team at national office develop the role specific mandatory annual education and training module/schedule. This includes topics relevant to all services and levels of care provided. Training is currently provided through study days repeated throughout the year. Online training with a quiz is currently being implemented throughout the Oceania facilities. There are electronic systems and processes in place to ensure that all staff complete their required mandatory training modules and competencies. The CM is responsible for alerting staff as to what training they need to complete and when training is overdue. Specific training is also developed and provided by the CM for staff. All RNs and some health care assistants have current first aid certificates.</p> <p>The CM and six of the eight RNs have completed interRAI assessment training and competencies. Care staff complete annual competencies or demonstrate awareness on specific tasks, for example medication management, restraint, moving and handling, and health and safety awareness. Education session attendance records evidenced that ongoing education is provided relevant to the services delivered. Interviews and training records reviewed confirmed that all staff, including RNs undertake at least eight hours of relevant education and training hours per annum. Health care assistants are encouraged to complete Careerforce training. Currently 11 HCAs have attained level 4, four have attained level 3 and one has attended level 2.</p> <p>An annual performance appraisal schedule is in place. All staff files evidenced staff have completed a current</p>

		performance appraisal.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The organisation's staffing policy provides guidelines to ensure staffing levels are sufficient to meet the needs of residents' acuity and the minimum requirements of the DHB contract. Staffing levels are determined by acuity, the layout of the facility and occupancy to ensure there is appropriate skill mix of staff available. Staffing is adjusted as residents' acuity changes. When required, additional staff are rostered on duty. The BCM reported additional RNs are rostered on the morning shift when RNs need to complete assessments and specific roles such as the coordinator for infection prevention and control.</p> <p>There are sufficient RNs and HCAs available to safely maintain the rosters for the provision of care. Rosters sighted reflected adequate staffing levels to meet current resident acuity and bed occupancy. The BCM and CM work fulltime Monday to Friday.</p> <p>On the morning shift there is an RN, a senior HCA who is medication competent and five other HCAs. On the afternoon shift there is an RN plus a senior HCA who is medication competent and five HCAs. On the night shift- an RN plus two HCAs and another HCA is rostered on when the number of residents increases to 49. The BCM and CM are on call after hours.</p> <p>Of the eight RNs, all are NZ trained apart from three who trained offshore. The RNs experience in aged care ranges from 18 months to 10 plus years, with the majority in the 10 year plus range.</p> <p>Observation of service delivery confirmed that resident needs were being met in a timely manner. Residents and families stated they felt there were sufficient staff on each shift to meet the needs of residents. Staff confirmed that they have sufficient time to complete their scheduled tasks and resident cares.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN and pharmacy check medications against the prescription, then every Thursday and Friday one RN and one HCA check each blister pack. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when</p>

		<p>administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. Controlled drugs are signed in by the RN and pharmacist and a pharmacy check is carried out every six months. This was evidenced in the controlled drugs register.</p> <p>The records of temperatures for the medicine fridge were reviewed and were within the recommended range. The medication room temperature is also monitored.</p> <p>Good prescribing practices were noted, included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used. Verbal orders are rare and must be given to a RN, then repeated to the HCA. The documentation is signed and scanned into the electronic patient notes. Vaccines are not stored on site. Ninety percent of staff have had the required COVID-19 vaccines and each resident has received their first vaccination with a date for the second in July.</p> <p>There were no residents self-administering medications at the time of audit.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site with a cook and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made in that review have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Ministry of Primary Industry which expires on the 28 March 2022. At time of audit the kitchen was observed to be clean, and the cleaning schedule was maintained.</p> <p>Food temperatures, including for high-risk items, are monitored, and recorded as part of the plan using an electronic database.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. The kitchen provides two menu plans which support residents with specific culture food requirements. Special equipment to meet resident's nutritional needs, is available.</p> <p>Evidence of residents' satisfaction with meals was verified by resident and families/whānau interviews, satisfaction surveys and residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews with residents and families verified that the care provided to the residents was consistent with their needs, goals and plan of care. The attention to meeting a diverse range of resident needs was evident in all areas of service provision. The GP reported that the service is providing, "A very pleasing level of care, I trust them". The GP interviewed confirmed that medical orders are carried out in a timely manner and staff are very proactive at contacting me should a resident's condition change. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources are available and suited to the level/s of care provided and in accordance with each resident's needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by a full-time activities co-ordinator who supports the residents Monday to Friday 8.30am until 5.00pm. The programme is overseen by the clinical manager. The activities co-ordinator was new to the role but expressed a wish to complete their national certificate in diversional therapy. A lifestyle and leisure assessment are completed, and a history undertaken "About Me" on admission to ascertain the resident's needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate a plan that is meaningful to the resident. The activities are evaluated daily and documented once a week and as part of a six monthly multi-disciplinary care plan review. They have one resident who identifies as Māori, they are greeted in their native tongue and support is given to anything culturally appropriate for them. Family are coming in to perform a Kapa Haka for the resident which they want to do and have invited the activities co-ordinator to watch. Activities reflect the resident's goals, ordinary patterns of life and include normal community activities, regular church services, housie, knitting, and visiting entertainers. There are individual and group activities offered and a weekly van outing. There are two lounge areas and an activities room as well as the individual's bedrooms where they could watch their own television or listen to the radio. The activities calendar is on display and each resident is given a copy of the weekly activities available for them to participate in. It emphasises and celebrates cultural beliefs on a regular basis.</p> <p>Residents and families have the opportunity to evaluate the programme through day-to-day discussions with the activities co-ordinator and by completing the six monthly resident satisfaction survey. Residents interviewed confirmed the programme was interesting and varied.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and documented in the progress notes. If any change is noted this is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the resident's interRAI re-assessment, or as a resident's needs change. Where progress is different from what is expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being constantly reviewed, and progress evaluated were noted for infections, wounds, weight loss. When necessary and for ongoing problems, long term care plans are</p>

timely manner.		added to and updated. Residents' families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is displayed at the main entrance to the facility that expires on the 8 September 2021. There have been no structural alterations since the last audit.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastro enteritis and other infections. The infection prevention and control (IPC) Coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Trends are identified from the past year, and this is reported by the clinical manager and reported to the business and care manager.</p> <p>Residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Healthcare assistants interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. There have been no outbreaks since the previous audit.</p> <p>Infection control measures recommended by the Ministry of Health for the management of COVID-19 pandemic were implemented.</p> <p>Residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Health Care Assistants interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. There have been no outbreaks since the previous audit.</p>
Standard 2.1.1: Restraint	FA	The restraint minimisation and safe practice policy includes a definition, assessment and evaluation details and complies with the requirements of the standard. The service has a restraint free philosophy. There were four

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>residents using an enabler and three residents using a restraint at the time of audit. Equipment is used, such as low beds, fallout mats and sensor mats, so that restraint is not required. Staff interviewed demonstrated a sound knowledge of the difference between a restraint and an enabler and the process should a resident request an enabler. Staff have received on-going education relating to challenging behaviours, enablers and restraint.</p>
--	--	--

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

No data to display

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.